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ADULT HEALTH HISTORY AND PATIENT INFORMATION

Please complete this form and bring it with you to your first session.

Biographical Information

Name: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Age: _____

Ethnic/Racial Identity: _____ Sexual Orientation: _____

Gender Identity: _____

Relationship Status: single/never married partnered married divorced/separated widowed

Living Situation: alone spouse/partner(s) parents roommate(s) children

Source of Income: _____ Occupation: _____ Employer: _____

Referred by: _____

Phone: _____ Is it OK to leave a message? ☐No ☐Yes

Email: _____ Is it OK to leave a message? ☐No ☐Yes

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Relationship to Patient: _____

Health/Medical History

How would you describe your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any significant medical issues (current/past)? ☐ No ☐ Yes

If yes, please describe: _____

_____

Date of last physical exam? _____ Known Drug Allergies: _____

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Any past hospitalizations, surgeries, or serious injuries? ☐ No ☐ Yes

If yes, please describe _____

Any past head injuries or injuries that resulted in a loss of consciousness? ☐ No ☐ Yes

If yes, please explain _____

Any family members with psychiatric or substance abuse problems (current/past)? ☐ No ☐ Yes

If yes, please describe _____

_____

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, please describe _____

_____

Have you ever tried to harm or kill yourself? ☐ No ☐ Yes

If yes, please describe _____

_____

Have you ever experienced suicidal thoughts? ☐ No ☐ Yes

How much alcohol do you currently consume? _____ drinks per week

Do you currently use recreational drugs? ☐ No ☐ Yes
If yes, which drugs and how often? _____

Previous Mental Health Treatment

Have you ever seen anyone for psychotherapy? ☐ No ☐ Yes

If Yes, (number of times/how long)? _____

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Are you currently under the care of a psychiatrist/psychologist/therapist? ☐ No ☐ Yes

If Yes (Name/Location) _____

Are you currently under the care of a physician? ☐ No ☐ Yes Physician's Name: _____

Current Medications (prescribed and over-the counter)	Dosage / Frequency	Prescribed by:	Date 1st prescribed	Side Effects

Please describe the concerns that have brought you to seek therapy at this time.

_____

_____

_____

_____

_____